Enter & View Visit to
Ronald Gibson House
Intermediate Care Unit
21st May 2018

Healthwatch Wandsworth

Acknowledgement

The Healthwatch Wandsworth Enter & View Team would like to thank the management, staff, patients, relatives and friends who made us welcome and assisted us in carrying out our visits and in preparing this report.

The Project Team

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Executive summary

Background

Intermediate Care (IC), which is still evolving, is intended to be a range of integrated services that promote faster recovery from illness; prevent unnecessary acute hospital admissions and premature admissions to long-term care; support timely discharge from hospital; and maximise independent living. IC services in Wandsworth are not yet fully integrated but include both home-based and bed-based care. In practice IC, particularly bed-based care, largely serves the needs of older people experiencing difficulty regaining their independence after illness, falls or other injuries.

In line with our strategic interest in the care of older people and following our Enter and View (E&V) visits to senior health wards at St George's Hospital in September 2017, we were invited by Wandsworth and Merton Clinical Commissioning Group (CCG) to visit the IC facilities at Ronald Gibson House (RGH) and at Mary Seacole Ward, Queen Mary's Hospital, Roehampton. This is the report of our visit to RGH, a 16-bed unit in a care home on the Springfield Hospital site with nursing care provided by the Brendoncare Foundation and rehabilitative therapy by St George's Hospital NHS Trust. We hope to carry out a visit to Mary Seacole Ward later in the year.

How we proceeded

We met the commissioning managers at the CCG in March 2018 to get a better understanding of the bed-based intermediate care service at Ronald Gibson House and how it fits in to wider services as well as to discuss the feasibility of an E&V visit and particular issues we might explore. As well as exploring patients' experience we could usefully look at how well the service was meeting IC objectives, in particular rehabilitation. We agreed to look at such issues within the limitations of our knowledge and experience. The commissioners also welcomed the suggestion that we should subsequently visit the Inpatient Elderly Rehabilitation Service at Mary Seacole Ward, which would provide a point of comparison for the IC unit at RGH.

On 8 May 2018 we paid a preliminary visit to Ronald Gibson House and met the Brendoncare Home Manager and the Clinical Team Leader for Therapies, employed by St George's Hospital. This allowed us to see the layout of the building, learn a great deal about the service from the perspective of the providers, firm up our

objectives, including the need to look critically at the setting of individual goals for rehabilitative therapy, and make practical arrangements for the E&V visit.

As agreed we carried out the E&V visit on 21 May. There were thirteen patients on the Unit on the day, with two admissions ongoing in the afternoon. One person was discharged. We interviewed eight patients and looked at eight sets of therapy goals. Three relatives and one paid home carer participated in the interviews. We also spoke to the GP responsible for medical oversight of the unit, the Patient Flow Coordinator and two other members of staff. We have analysed the findings from our interviews and our observations in the light of all the other information we were given and have set these out (in anonymised form where appropriate) under general headings in our full report.

Conclusions and Recommendations

The role identified for bed-based intermediate care is clearly an important one. All the evidence seems to show the unit at Ronald Gibson House is making a good job of this in a positive homely environment within a nursing home. In particular, nursing care and collaborative personalised rehabilitative therapy is provided in a flexible and sensitive manner to mainly older people in need of "step-down" help, allowing them to return home within a relatively short period after hospitalisation following illness, falls and other injuries.

The balance of the feedback we received from patients and their relatives about the standards of care at RGH was positive although there were a few negative comments and some concerns. We suggest some areas for possible improvement below.

A significant minority of patients expressed the view that more nursing staff were needed. While we cannot take a definite view, this needs to be considered.

Some of the feedback also led us to wonder about the optimum level of rehabilitative therapy, in particular physiotherapy, in bed-based IC. We are not in a position to advise a more intensive approach but we believe the issue could usefully be looked at.

Nor can we comment on the balance of supply and demand for bed-based IC in Wandsworth but in our view there is a clear need for continuing provision at an adequate level. We may come back to some of these issues after further enquiries including visiting the Mary Seacole Ward at Queen Mary's Hospital, Roehampton.

More detailed suggestions for improvement include:

Care

- Staff should be reminded of the need to protect patients' privacy and dignity, especially at busy times such as the early morning.
- More attention should be paid to giving medication at appropriate times and, in preparation for discharge, encouraging patients to take their own medication where possible.
- Clearer information about the GP's availability and role could be made available to patients.
- More care should be given to meeting the needs of patients with special dietary requirements.
- Staff should be mindful of patients who are largely confined to their rooms by their physical condition or state of mind. They may need information about activities and encouragement to come out and participate.
- The home should discuss with commissioners the need for a laundry service for patients as an alternative to relying on relatives to provide this. This would ensure all patients could wear their own daytime clothes which we thought contributed positively to their rehabilitation.
- We see the absence of any nearby shopping facilities for simple items patients need as a problem. Consideration should be given to how this could be addressed.

Rehabilitation

- It might be possible to do more during a patient's stay to reinforce awareness of the risk of falls and the various interlocking strategies for avoiding them. Greater prominence should be given to the need to identify and implement individual falls prevention strategies.
- We would like to see goals broken down into their constituent steps, expressed in plain English and for a copy to be given to patients.
- Documentation of therapy goal-setting and monitoring should be reviewed and monitored for adherence.

Information for patients and families

- In any redesign of information material for patients and their families, more prominence could usefully be given to providing clear advice on who to contact with any queries and concerns.

Discharge

- To reduce confusion and anxiety, the unit should identify more clearly when patients enter a "preparation for discharge" stage and, for example, mark this with use of a discharge leaflet for patients and relatives.

The Full Report: Contents

1.0 Introduction 7

1.1 About Healthwatch Wandsworth 7

1.2 Enter & View 7

1.3 Our E&V strategy 7

2.0 Background 8

2.1 Bed-based intermediate care Services: national guidance 8

2.2 Local intermediate care services 9

2.3 Information about IC at Ronald Gibson House obtained from external sources 10

2.3.1 CQC reports 10

2.3.2 Age UK Wandsworth 10

3.0 Preparing for our visit 11

3.1 Meeting with Commissioners 19 March 2018 11

3.2 Meeting with managers at Ronald Gibson House - 8 May 2018 11

3.2.1 What we learned about the service 11

3.2.2 The layout and facilities of the intermediate care unit 14

3.3 Identification of objectives for our visit 15

4.0 Our visit 15

5.0 Our findings 16

5.1 Overview of our visit 16

5.2 Referral pathway 16

5.3 Patient care and facilities 17

5.4 Rehabilitation 21

5.5 Working with carers, family and friends 22

5.6 Discharge planning 23

6.0 Overall conclusions and recommendations 24

6.1 Conclusions 24

6.2 Recommendations 25

The Full Report

1.0 Introduction

1.1 About Healthwatch Wandsworth

Healthwatch Wandsworth (HWW) is the patient and public champion in the areas of health and social care services. At the national level, we send our reports to Healthwatch England. HWW is funded by the Department of Health through the local authority, Wandsworth Borough Council. Our staff and volunteers are managed by an independent local voluntary organisation, Wandsworth Care Alliance (WCA). HWW is governed by an Executive Committee consisting of four Trustees of WCA and four members directly elected by the community. Our activities are developed in consultation with the public at our Assembly meetings and as we collect feedback from people about their experiences of health and social care in Wandsworth. To decide on where to focus our work we look at what people have told us when taking part in our surveys or sharing experiences with us, we speak to local health and care decision makers to hear about their plans to develop services and we use information on local health data to set our priorities.

1.2 Enter & View

Healthwatch Wandsworth has the statutory authority to visit health or social care services provided in the borough, or which cater for the local population but are located outside the borough. We can observe how services are delivered. Our main aim is to talk to patients or clients, their close relatives or carers, and senior staff responsible for managing the services. Our main focus is on the service user's experience of care.

Our Enter & View (E&V) volunteers receive full training and are DBS (Disclosure & Barring Service) checked before they can become authorised visitors. After each visit, the team produces a report containing its findings and recommendations. The reports are then sent to the service provider for comment, and to relevant bodies such as Healthwatch England, the Care Quality Commission (CQC), and those responsible for commissioning and providing the service we have visited. Finally, our reports and any responses from the service provider to our recommendations are posted on the Healthwatch Wandsworth website.

1.3 Our E&V strategy

One of the main aims of our current E&V strategy is to collect feedback on the experience of patients of St George's University Hospitals NHS Foundation Trust, which is the main provider of acute care services in Wandsworth. The team (and

its precursor LiNK) has also had a longstanding interest in services for older people in a range of settings and has visited care homes and Extra Care housing as well as looking at discharge procedures at St George's and visiting Crocus Ward at Springfield Hospital. Most recently, (September 2017), we visited the wards for older people at St George's Hospital. Our reports can be found on the Healthwatch Wandsworth website.[1] We have been aware of the pressures on acute hospital beds and on the development of other options for the provision of care. We were invited by Wandsworth Clinical Commissioning Group (CCG) to visit the intermediate care facilities at Ronald Gibson House and Mary Seacole Ward, Queen Mary's Hospital Roehampton and this seemed to fit within our strategy and interests.

2.0 Background

2.1 Bed-based intermediate care services: national guidance

Intermediate care was developed in response to several reports in the late 1990s highlighting that there was too little investment in preventive and rehabilitation services and that about 20% of bed days for older people were probably inappropriate and could be avoided by the provision of alternative facilities.[2]

As a term, intermediate care was first mentioned in the NHS Plan of 2000 and fully defined in the 2001 National Service Framework for Older People (NSF-OP):

> *Aim: To provide integrated services to promote faster recovery from illness, prevent unnecessary acute hospital admissions, support timely discharge and maximise independent living.*
>
> *Standard: Older people will have access to a new range of intermediate care services at home or in designated care settings, to promote their independence by providing enhanced services from the NHS and councils to prevent unnecessary hospital admission and effective rehabilitation services to enable early discharge from hospital and to prevent premature or unnecessary admission to long-term residential care.*

It was intended that care should be person-centred, time-limited, focused on rehabilitation and delivered by a combination of professional groups as part of a

[1] https://www.healthwatchwandsworth.co.uk/resources/enter-&-view-report
[2] Department of Health. *The national service framework for older people*. London: DoH, 2001. www.dh.gov.uk/assetRoot/04/07/12/83/04071283.pdf (accessed 16/04/18 - go to archived link)

whole system approach. Professor Ian Philp, who was the Czar for the NSF-OP, also said what intermediate care should not be:[3]

- *marginalising older people from mainstream services (a ghetto service)*
- *providing transitional care for older people pending long-term placement (a hotel service)*
- *solely the responsibility of one professional group (a dumping service)*
- *indeterminate care (a dustbin service)*
- *a means of funding all good things for older people (a honeypot service)*

A wide variety of services have evolved over the years and they continue to evolve but the principles of avoidance of inappropriate hospital admissions or stays, by providing time-limited multi-disciplinary rehabilitation services, free at the point of delivery, remain. The National Institute for Health and Care Excellence (NICE) recently published guidance and information about it.[4]

The NICE guideline defines intermediate care as a range of integrated services that: promote faster recovery from illness; prevent unnecessary acute hospital admissions and premature admissions to long-term care; support timely discharge from hospital; and maximise independent living. Intermediate care services are usually delivered for no longer than 6 weeks and often for as little as 1 to 2 weeks. Four service models of intermediate care are available: bed-based, crisis response, home-based intermediate care, and reablement.

2.2 Local intermediate care services

This report concerns an Enter and View visit carried out on 21 May 2018 to the bed-based service at Ronald Gibson House, a 16-bed unit on the Springfield Hospital site with basic care, including nursing, provided by the Brendoncare Foundation and rehabilitative therapy provided by St George's Hospital NHS Trust. We are conscious that in looking at the unit at Ronald Gibson House we are only looking at a part of what may be considered as the overall provision of intermediate care services in Wandsworth, which is not yet fully integrated. The Inpatient Elderly Rehabilitation service (Mary Seacole Ward), a 42-bedded unit at Queen Mary's Hospital, Roehampton, while not yet as we understand it explicitly categorised as an intermediate care service, serves a very similar function and is likely to be included in any integrated intermediate care service in future. Community-based intermediate care, currently provided in Wandsworth by Central

[3] Quoted in a King's Fund Guide https://www.kingsfund.org.uk/sites/default/files/Developing-Intermediate-Care-guide-health-social-services-professionals-Jan-Stevenson-Linda-Spencer-The-Kings-Fund-July-2009.pdf

[4] Intermediate Care including reablement. https://www.nice.org.uk/guidance/ng74

London Community Healthcare NHS Trust, is also a major component, which we have not attempted to bring into this enquiry.

As we understand it, intermediate care in Wandsworth came into being in response to the NSF-OP. Over time, beds have been provided at the former Bolingbroke Hospital, Queen Mary's Hospital and Dawes House. We believe that the unit at Ronald Gibson House came into service when similar provision at Dawes House was closed. We have seen the current service specification for the bed-based intermediate care service at Ronald Gibson House dated 31 March 2016.[5] A description of the service as we found it in preparation for and during our E&V visit is given at Sections 3.2.1 and 3.2.2 below.

2.3 Information about IC at Ronald Gibson House obtained from external sources

2.3.1 CQC reports[6]

When we started planning our visits to IC services, the latest CQC report on Ronald Gibson House was in December 2016 and followed a full visit in January 2016. The visit was to the home as a whole and did not focus especially on IC. The home was rated as "Good" in four areas (Safety, Caring, Responsiveness and Well-led) and issues were identified which "required improvement" under "effectiveness". These related to mental capacity and consent and were confined to the unit for people with dementia.

We learned subsequently of a visit in March 2018 with the report being published on 28 April. That report was also on the home as a whole and all areas were rated as "Good". Mention of IC was made under care plans where it was noted that for people in the "short term rehabilitation unit care plans [were] shorter and focussed on the support required for them to return home." It was also noted that there were clear policies about communication with community services and that this was especially necessary for people in the IC unit.

2.3.2 Age UK Wandsworth

We contacted Age UK Wandsworth and were told that they did not have any specific feedback about Ronald Gibson House.

[5] Referred to as Intermediate Care Bed Based Service (ICBBS)
[6] 2016 and 2018 reports can both be found at: https://www.cqc.org.uk/location/1-123853839/reports

3.0 Preparing for our visits

3.1 Meeting with Commissioners, 19 March 2018

On 19 March six members of Healthwatch Wandsworth E&V team met with the commissioners of intermediate care services, Sandy Keen, (Head of Integrated Care, Wandsworth and Merton CCG) and Jeragitha Vasan, (Project Manager, Wandsworth and Merton CCG) to get a better understanding of the bed-based intermediate care service at Ronald Gibson House and how it fits in to wider services as well as to discuss the feasibility of an Enter and View visit and particular issues we might explore.

The commissioners explained that further integration of intermediate care services was being planned but had yet to be achieved. Other information which the commissioners gave us about the intermediate care unit at RGH is incorporated in the description of the service given below in section 3.2.1.

The commissioners welcomed our plans to carry out an Enter and View visit to the intermediate care unit at Ronald Gibson House. While we should maintain our normal focus on patients' experience we could usefully look at how well the service was meeting the objectives of intermediate care, in particular the provision of personalised, collaborative rehabilitative therapy designed to increase people's independence. We agreed to look at such issues within the limitations of our knowledge and experience. The commissioners undertook to make introductions for us to the Home Manager and Therapy Team Leader at RGH.

The commissioners welcomed the suggestion that we should subsequently visit the Inpatient Elderly Rehabilitation Service at Mary Seacole Ward, Queen Mary's Hospital, Roehampton, which would provide a point of comparison for the IC unit at RGH.

3.2 Meeting with managers at Ronald Gibson House, 8 May 2018

Four members of team met with Victor Njoku, General Manager, Brendoncare and Paula Sargent, Clinical Team Leader for Therapies, employed by St George's Hospital, in preparation for the main visit. This was to see the layout of the building, to understand the service from the perspective of the providers, to firm up our objectives and to make the practical arrangements for the visit itself.

3.2.1 What we learned about the service

The service, jointly run by Brendoncare and St George's Hospital Foundation Trust, is seen by its managers as essentially there to provide care and rehabilitation to elderly people who would otherwise have prolonged stays in hospital. The patients

are usually admitted from hospital with complex medical problems needing 24-hour care, following treatment and care for a variety of reasons including illness, sepsis, fractures, frequent falls, or existing health problems which have become a concern or impacted on their ability to be as independent as they were prior to their hospitalisation. Some have renal problems requiring attendance at dialysis clinics. Some have a degree of dementia or temporary delirium. But all are assessed as capable of engaging with and benefitting from rehabilitative therapy to restore mobility, confidence or daily living skills. All patients agree to a period of rehabilitation and agree initial goals with referring services and sign a statement of intent for rehabilitation. The goal is to return people as far as possible to a level of independent living, and in the great majority of cases to enable them to go home. The service is no longer constrained by a 6-week time limit but the average length of stay is currently around 28-30 days.

The stated aims of intermediate care (e.g. in the relevant NICE guideline) include preventing unnecessary hospital admissions. In practice the service at RGH no longer contributes to this "step up" function and changes in the organisation of community health services have disrupted the previous pathway. A new limited pathway has been opened up involving referral through the Rapid Access Clinic at the Brysson White Unit at Queen Mary's Hospital, but no such referrals have yet been made.

We asked how the service at RGH differed from that provided by the Inpatient Elderly Rehabilitation Service at QMH (Mary Seacole Ward). The main difference was seen to reside in the fact that RGH provides a more homelike environment, aiding the transition back to the patient's home, but lacks the specialist diagnostic and medical facilities available at an acute hospital and cannot therefore handle the more acute medical conditions which Mary Seacole can.

As many as 90-95% of referrals to IC at RGH come from St George's Hospital. A number of wards there, including the senior wards and A&E, have staff trained as "trusted assessors" who complete the necessary assessments. The referrals are sent to the RGH team and each person's potential for rehabilitation and their nursing needs are reviewed by all the team as well as the Patient Flow Coordinator. Any further information required is then sought before admission is agreed. In the case of other referrers, RGH's Patient Flow Coordinator (currently a Band 7 Nurse) has to visit and assess the patient herself. The Deputy Manager, who is also a Registered Nurse, also undertakes visits to assess patients. When complex cases are referred both will assess patients. We were given a copy of the form used for referrals which covers the patient's medical history and current condition as

well as therapy needs and the patient's goals.[7] While in practice the Patient Flow Coordinator, employed by St George's, takes most decisions on the suitability of patients, referrals are discussed by the combined therapy and nursing team at RGH before admission is agreed. Brendoncare, as the registered provider with the CQC, have the ultimate right and responsibility whether to accept or refuse a referral. Patients transferred from St George's are formally discharged from the hospital.

Patients referred to IC at RGH, and their relatives/carers, are given a 3-page leaflet which explains intermediate care and what they can expect to happen during their stay at RGH.

Within 24 hours of admission all patients receive a medical assessment. Patients also receive a mobility assessment within 24 hours, a full Physiotherapy assessment within 48 hours and an initial OT assessment within 72 hours. The latter two assessments both include the setting of rehabilitation goals to be achieved with the help of therapy during the patient's stay. The goals are required to be agreed with the patient and to be SMART (Specific, Measurable, Achievable, Relevant and Timed) and are put in their care plan folder along with other information mainly of a medical nature. Care plans, which are reviewed at least once a week, are held in the nursing office. Patients' progress against their therapy goals is monitored by the relevant therapists throughout the patients' stay and recorded.

Nursing care is delivered by a team of nurses employed by Brendoncare. Daytime care is provided by two qualified nurses and two care assistants, while the night shift comprises one nurse and two care assistants. While there is some rotation of nursing staff between the IC unit and the other residential care units (known as "households") at RGH, the home manager told us it was his aim to retain a "spine" of about 70% of the nursing staff who were primarily attached to the IC unit. Nursing staff and the care team in the IC unit are overseen by the Deputy Manager. Medical care is provided by a GP, who works for 18 hours spread over 6 sessions a week at RGH and is employed by St George's under the supervision of a consultant geriatrician.

The therapy team, employed by St George's, has a Clinical Team Leader (a physiotherapist by background, who has additional responsibilities off-site) and a complement of 1.5 wte[8] OTs, working Monday to Friday, and 2 wte physiotherapists (made up in practice by 1.5 posts working Monday to Friday and 0.5 covering weekends). There are also 3 rehabilitation assistants, with at least 1 on duty each day. An exercise group is held daily in the gym (with a maximum

[7] The form is headed Transfer/Discharge Form, and apparently based on a standard SGH form with adaptations for use with IC at RGH and with Mary Seacole Ward at QMH.
[8] "wte" stands for whole time equivalent

capacity 4 or 5 patients). The therapy team is clearly a small one, but we were told that patients are seen daily by either a physiotherapist or rehabilitation assistant for exercise or mobility therapy whether in a group or for 1:1 exercise. Although there is not a full "rehab. kitchen", assessment and support for meal preparation skills can be provided in a small patients' kitchen. Home visits where possible are also used for some assessment/therapy purposes. The Patient Flow Coordinator is also employed by St George's. The role is full time and was initially based at RGH five days a week but now covers other aspects of services at SGH and she is on site on average three times a week, as agreed with the CCG.

3.2.2 The layout and facilities of the intermediate care unit

The IC service is on the ground floor of Ronald Gibson House. There are 16 single rooms on two corridors forming part of a U-shape. The third part of the U contains staff offices and a small therapeutic gym. The hairdressing room for the whole building is also on this corridor. There is also a very large meeting room which is generally used for staff training rather than by patients.

IC patients can use the large open lounge near the Reception desk which is also shared by permanent residents of the home (mainly on upper floors). Near this area is the IC team office which is also used by the GP and Patient Flow Coordinator. Activities, listed on a whiteboard, take place in this area and include visits from mothers with young children. Patients can eat either in their rooms or in the ground floor dining room which includes a conservatory. They can also use sitting rooms on other floors (we did not visit these areas) and the spacious gardens. The rooms have hi-lo beds with a variety of different mattresses to meet patients' needs and they have en-suite toilet and washbasins. They have low windows so that patients can look out from a seated position. Some overlook a garden but others look out on the car park with flowered borders and trees. There is an assisted bathroom with separate shower within the same room for each set of eight rooms and additional assisted toilets. There is no zoning to separate the genders which is not considered necessary as patients' have individual en-suite rooms.

The two corridors with patients' rooms were carpeted and the third, with other facilities, had laminate flooring. Some patients' rooms are carpeted and some have laminate flooring. This is apparently to give patients a choice of flooring and to meet some patients' special needs. The corridors have handrails but they seemed quite narrow, such that it might be difficult for two patients with walking aids to pass. They were also quite cluttered at the time we visited as there was cleaning taking place with a vacuum cleaner with trailing cable.

The gym is small but has parallel bars for practising walking and also a set of stairs. It is a space which can accommodate at most five patients.

3.3 Identification of objectives for our visit

Following the meeting with commissioners and our preliminary visit to Ronald Gibson House, we decided that the Healthwatch E&V visit would look at the RGH service with the key objectives being to look at patients' and staff views of:

- How well the IC pathway to Ronald Gibson House was working, including discharge planning;
- Patient satisfaction with care and facilities;
- How far rehabilitation care, including goal-planning, seemed to be meeting the objectives of IC;
- The views of family and other carers.

4.0 Our visit

Four members of the Enter and View team visited RGH on Monday 21st May 2018 from 9.15am to 5pm. We knew that the Manager, Victor Njoku, would be on leave but it was not possible to find another convenient date. We had sent a letter to patients and relatives explaining our visit in advance, and a poster to inform relatives, but, unfortunately, the poster was not put up and the letters were not given out until the morning of our visit.

The receptionist was not aware that we were coming but we were rapidly welcomed by Francesca Dekker, Head of Quality and Compliance from Brendoncare Head Office, who spent the day on site and Paula Sargent, Clinical Team Leader for Therapies, who was on site all morning. We also met Serpill Mitchell, a Peripatetic Manager, who said that she sometimes came when the manager was on leave and Maris Ratsep, the Deputy Home Manager, who was also on site.

We were able to use the meeting room as a base and refreshments were kindly provided for us.

There were thirteen patients on the Unit on the day, with two admissions ongoing in the afternoon. One person was discharged. We interviewed eight patients and looked at goal plans for eight people (seven of whom we interviewed – see below). Three relatives and one patient's paid home carer were present during the interviews and these were conducted jointly with the patient and relative or carer. We also spoke to the GP, the Patient Flow Coordinator and two other members of staff.

5.0 Our findings

5.1 Overview of our visit

Person-centred rehabilitation is central to the whole concept of intermediate care. A vital component is the setting and monitoring of individual therapy goals. We accordingly decided that as part of our E&V visit we would need to carry out a critical review of the process of goal-setting at RGH and the therapy goals set for individual patients. We mentioned this at our preliminary meeting on 8 May and, as agreed, on arrival for our E&V visit we were given, with the patients' consent, copies of the individual goal summaries for eight out of the thirteen patients then in the unit. One patient withheld consent. We were told that the remaining four patients had been admitted within less than a week and had not yet had their therapy goals identified. We were able to compare the goal sheets with what we were later told by patients themselves. The results of our review of goal-setting are summarised under 5.4 Rehabilitation below.

After examining the goal sheets, we proceeded to interview eight patients in all, including seven of those whose therapy goals we had seen (the remaining one whose goals we had seen was discharged before we were able to conduct our interview). Of the eight patients interviewed seven were female and one male. One was under 60, while the others ranged in age from 67 to 93. Five were White British and three of BME ethnicity.

During three of our interviews with patients a visiting relative or relatives were present, while another patient had their paid home carer with them. The visitors participated in the conversation and contributed their point of view.

We also spoke to the GP responsible for patients while they are in the IC unit at RGH, the Patient Flow Coordinator, a Senior Physiotherapist and one of the care assistants on the day shift.

The anonymised findings of our interviews together with the results of our observation are set out below under a series of general headings. Gender-neutral pronouns are used throughout.

5.2 Referral pathway

Of the patients we interviewed, six had been referred from St George's Hospital and two from the Chelsea and Westminster Hospital. Two patients had been at RGH about a week, two for 2 weeks, two for 4 weeks, one for 6 weeks, and one for about 8 months (this patient was an exception to the norm in various respects owing to a combination of medical and other circumstances). We were told that the patient discharged that morning had been at RGH for less than a week but felt

ready to go home. The other patients we did not interview had all been at RGH for less than a week. Four of the patients we interviewed had been in the IC unit at RGH on one or more previous occasions.

No one reported significant difficulties arising from the referral or transfer process. Most of the patients had been in hospital for some time before referral but in two cases patients had been referred after only one night in St George's Hospital. One of the patients referred from Chelsea and Westminster had apparently been told that they would be transferred either to RGH or to Mary Seacole ward at QMH but had to wait for two weeks before a place became available. Another patient who had been in St George's a number of weeks said that they had only heard about RGH on the day of transfer and would have liked more information at the time, but they were happy with the information received since arrival.

We did not specifically ask about patients' medical conditions but it was apparent that the majority had mobility problems of varying degrees of severity resulting mainly from repeated falls, fractures, or leg ulcers, sometimes complicated by other medical conditions such as kidney, heart or neurological problems. Several patients clearly experienced pain. One patient had additionally been diagnosed with mild dementia.

Apart from one patient who currently had no home to go to, all of those we interviewed were expecting to be able to return to their previous homes after their stay at RGH. Some would need additional support from carers at home: several already had such support in place.

The Patient Flow Coordinator was happy with the present arrangements for assessing patients for admission to the IC unit at RGH whether involving "Trusted Assessors" or her own participation. The main questions she needs to satisfy herself about are whether the patient is medically fit enough to be managed at RGH where they have single rooms and less close observation than at Mary Seacole Ward. They need to be able to be cared for in single en-suite rooms, not requiring line of sight care (such as a 'bay' in hospital) and this means that generally they do not have much cognitive impairment.

The GP, Dr Arshad, told us that in her view, most referrals to RGH are appropriate and we saw and heard nothing which conflicted with this.

5.3 Patient care and facilities

The overall balance of the feedback we received from patients was positive. Five of the eight patients we interviewed explicitly said they liked being at RGH or were happy there, while another patient used expressions like "OK" or "not bad".

Two patients had more mixed views, with a number of critical as well as positive comments.

One patient commented on the restful setting. Another particularly liked having their own room with en-suite toilet and washbasin. Two visiting relatives commented favourably on the cleaning. One patient said that the rooms were not cleaned thoroughly enough between occupants.

Five patients gave positive feedback on the attitude of staff, using terms like "good", "kind", "considerate", "respectful" or "cheerful".

One patient compared the nursing care at RGH favourably with that on an inpatient ward at St George's. The relative of another patient however felt that standards at Chelsea and Westminster Hospital were better than at RGH. Another patient said that the nursing care "varies".

We heard from half of the patients we interviewed that nursing staff were busy and that this was sometimes reflected in failure or slowness to respond to a call, discontinuity (staff moving on in the middle of a task and another coming to finish it), skimping ("a wipe instead of a wash"), unwillingness to listen or to help a patient with medication (see below). Two patients mentioned specific recent instances when staff seemed to be short-handed; others felt there were not enough staff, particularly at weekends, or not as many as when they were in the IC unit on a previous occasion. One patient commented on the number of staff changes. One patient however said that there were "plenty" of staff and that they responded to calls within 2 or 3 minutes; and another felt that help was readily available.

One patient complained to us about their privacy being invaded when staff went in without awaiting a response to their knock at the door and then banged on the locked toilet door. This patient also objected to staff coming in and turning on the light in the early morning despite being asked not to. But a larger number of patients said they were treated with respect for their dignity and privacy. One patient told us they liked to leave the door open to stay in touch with what was going on outside and were pleased when staff looked in to see how they were.

When we arrived for our visit shortly after 9am we passed a number of bedroom doors propped open with patients who were not fully dressed visible from the corridor. Later in the day, we observed that patients were mainly appropriately dressed in daytime clothes and we did not see anyone in bed.

Three patients mentioned issues regarding medication. One patient who was on a lot of medication said they sometimes had to remind staff about it as they otherwise did not give all of it. Another patient is required to take medication

before eating and at a different time from other medication: despite asking for it to be administered at 8am as at home, it is not given until 10am. The patient's perception was that this was because of staff shortages and limitations on access to the medicines cupboard. However the patient told us that they had just reported it to the GP at the time of our visit and we have since been told that the timing of medication was adjusted after that. Another patient mentioned a similar issue about taking medication before meals which they had resolved by taking responsibility for the medication themselves.

One patient and their relative felt that nursing staff and the therapy team did not communicate well and were "disconnected". On the other hand, one patient told us that the nurses and therapists worked well together and another said that everyone works as a team and messages get passed on. All the staff members we spoke to reported that they felt part of a combined team working closely together and supported by management.

We asked a number of patients whether they knew who they could speak to if they had any concerns. Two patients and the relative of a third said they would speak to "the Manager" (presumably the Care Home Manager). One patient would speak to the nurse in charge at the time: they always knew who this was. Another patient would speak to "one of the helpers". We observed that the patient information leaflet contains a paragraph inviting patients to let a member of the intermediate care team know if they have any questions or concerns or to contact the home manager or therapy team leader (telephone numbers given). This information is on the front page of the leaflet but only at the end of a section on "What is intermediate care?".

One patient was continuing to attend dialysis sessions outside the unit and two other patients mentioned appointments they were keeping or had kept at a fracture clinic and a prosthetic rehabilitation clinic. The GP, Dr Arshad, told us that she had strong links with the Acute Medical Unit (AMU, Richmond Ward) at St George's where she can access a next day appointment in their clinic by contacting the consultant on call directly and avoiding the need for a visit to A&E for patients who can wait until the next day to be seen. But another patient had apparently missed an appointment at the Moorfields eye clinic at St George's and seemed resigned to catching up with their treatment after discharge from RGH. We were later told that this had happened because the letter had gone to the patient's home. We also talked to a patient who was clearly hard of hearing but did not have hearing aids. (We were subsequently told that the need for hearing aids had been suggested to the patient on more than one occasion but they had chosen not to have them).

One patient said that they "would like the Doctor to be available a little bit more". Four other patients however mentioned having seen the Doctor and knew they could ask to see her if they needed to. Dr Arshad told us that after her initial "clerking" and medication review patients can see her on request from themselves or staff and she also plans to see patients who she thinks need to be reviewed. We noticed that the patient information does not mention the GP, her role or availability.

We observed that the hairdresser was working at RGH on the day of our visit and at least one of the patients we interviewed was intending to have their hair done.

We asked patients about meals at RGH. With the exception of two patients, all of those we asked were satisfied or very satisfied with the quality and range of food provided. Breakfast came in for particular praise from one patient and a relative said that in getting three meals a day their relative was eating better than at home. Two patients who had special dietary requirements for medical reasons were to a greater or lesser extent dissatisfied with the food provided at RGH and said that the nurses should know more about special diets. One said that the care assistants did not remember that they need a special diet.

The patient information leaflet states that patients are encouraged to take their meal times in the dining room. One patient mentioned that, while aware of the Unit's preference for patients to come to the dining room for meals, they had no difficulty in asking for their meals to be served in their room.

One patient confirmed that they were free to get up and go to bed when they chose and could have a bath or shower as often as they wanted although another mentioned only having had a wash and not a shower or bath.

We asked a number of patients how they passed their spare time and if they were happy with the amount of activity provided for them at RGH. Three patients told us they were content mainly staying in their room and watching TV (provided free) or reading magazines. Another patient, who also mainly watched TV or listened to their radio, felt they "did not have a lot to do here". Another patient, whose mobility was currently quite restricted and found it difficult leaving their room, nevertheless felt that more could be done to inform patients about activities and to encourage them out and they remembered there having been more entertainment and more social contact during their previous stay at RGH.

The patient information leaflet states that RGH is unable to provide a laundry service for patients' clothes and asks family and friends wherever possible to launder any items of clothing at home. We were told by the Home Manager during our preliminary visit that in practice where necessary RGH can launder essential

items for patients who have no other recourse. One patient who has limited scope for relying on relatives for support raised this with us as a concern. They considered it should be possible for RGH to arrange a paid laundry service for patients who wanted it and that relying on relatives was potentially embarrassing and infantilising.

Another concern raised with us was the absence at the RGH site of any nearby shopping facilities for newspapers, snacks, toiletries etc.

5.4 Rehabilitation

As explained above, rehabilitative therapy is the predominant purpose of bed-based intermediate care.

We are satisfied on the basis of our review of individual therapy goals and our interviews with the patients themselves that the bed-based IC service at RGH does indeed undertake a thorough process of collaborative and personalised goal-setting as a basis for its rehabilitative work with patients). Goals are clearly driven by individual patients' needs and preferences. Goal-setting is conducted in consultation with patients and, where appropriate with their family, or carer and in the light of their daily life and home circumstances. Attention is paid to ensuring goals are SMART (Specific, Measurable, Achievable, Relevant and Time-related). We felt that the goals were also usually sufficiently ambitious to make a real difference to people's capacity for independent living.

The individual therapy goals we saw were mostly concerned with mobility, including climbing stairs, toileting, washing and dressing, meal preparation and managing medication.

The majority of patients we interviewed clearly indicated that they were aware at least in general terms of the goals towards which they were working with the therapy team and that the goals were the right ones for their particular circumstances. Fewer specifically mentioned having been directly involved in the goal-setting process but most displayed little knowledge of the detailed objectives against which their progress was being measured or the relevant timescales. The member of the therapy team to whom we spoke confirmed that the patient normally suggests the end goal (e.g. "I need to be able to walk again") but the detailed formulation of goals is not shared with the patient. We observed that the documentation of patients' goals we were shown was usually expressed in technical language, using jargon and abbreviations unfamiliar to the non-professional and we saw no clear documentation of patients' agreement.

We also observed that some of the documentation we were shown was apparently incomplete in that the therapist's signature was lacking or that achievement or otherwise of goals within the specified timescale was not recorded.

The majority of patients were conscious of having made progress during their stay, although for some progress was inevitably slow. There were two specific compliments for the therapy team. The therapy staff were described as "very nice" and the physiotherapy as "good". But two patients and a relative said they would like to see more frequent or longer physiotherapy sessions and another missed the "Fun Keep Fit" sessions she remembered from a previous stay at RGH. From what we were told at the preliminary meeting on 8 May we gained the impression that the availability of therapy is to some extent constrained by the size of the therapy team. The therapy team member whom we spoke to however said that generally she feels that she has enough time to work with patients: most patients are seen by a qualified therapist or a rehab. assistant once a day and sometimes, when the unit is not full, they can offer two sessions a day.

Given the number of times that patients mentioned falls to us, we were surprised to find no specific reference to the concept of falls prevention in the goal-setting documentation for patients or elsewhere, e.g. in the information leaflet for patients and their families. Although much of the physical therapy at RGH consists of strength and balance training of the kind that forms the core of standard falls prevention programmes, there was no specific mention in any goal sheet that we saw of individual falls prevention goals or risk-oriented assessment of the home environment.

5.5 Working with carers, family and friends

All but one of the patients we interviewed had regular or occasional visits from family, friends or paid carers and four patients had visitors at the time of our interview, all of whom described the unit as welcoming. We noticed that the patient information leaflet listed "normal visiting hours" but invited patients to speak to the unit manager or nurse in charge to make other arrangements for their visitors if necessary.

Four patients mentioned staff making contact with relatives to pass or obtain information. The paid carer visiting a patient said they felt able to contact staff at any time. One patient however said their family was not given enough information even when it was specifically requested. As the family member was in full-time employment, and had to travel a considerable distance to visit, it was sometimes necessary to request information by telephone, but that the information was not always readily available; and it was difficult to establish who should best be contacted for information.

5.6 Discharge planning

We were told that discharge planning starts immediately after admission in that an expected discharge date is set by the team and subsequently kept under review. The extent to which patients need to be involved in discussing aspects of discharge however presumably depends to some extent on their progress in their journey through intermediate care. The GP, Dr Arshad, made clear that in her view the main driver for patients' discharge is the achievement of rehabilitation goals, as remaining nursing needs can often be met in the community. The patients we interviewed were clearly at different stages in their journey.

Three patients who had been at RGH between 4 and 6 weeks were presumably closest to being discharged. Of these, one was hoping to be discharged very soon and was happy with the information they had received (during our interview an OT looked in to carry out a kitchen assessment and discuss discharge). Another patient did not feel involved in discharge planning but was aware that an OT was going to do a home visit shortly. They felt that they were going to need home care which they had not had before but this did not yet seem to have been discussed. The third patient knew they were going home soon but no date had been fixed; following a home visit with the OT there had been a muddle about delivery of equipment (messages about delivery had been sent to the patient rather than to a relative) and the relative did not feel well enough informed about arrangements for the patient's discharge. None of the patients mentioned having seen a pre-discharge leaflet.

Four of the other patients we interviewed had been at RGH for two weeks or less. Of these, two already had all necessary adaptations or support arrangements in place at home. Another patient had some carer support in place but thought they would probably need more but this had yet to be discussed. The fourth patient who had only been at RGH for a week and had considerable progress to make with mobility was nevertheless worried about the adaptations likely to be needed, including bathroom arrangements, and the question of carer support, and did not know who to ask about these concerns.

For the remaining patient we interviewed, their medical and social circumstances have combined to make their future destination problematic and a social worker had been allocated to resolve matters. Such a combination of circumstances seems to us likely to be rare but not unique. By continuing to support this patient beyond the usual time limit the intermediate care service seems to us to be demonstrating commendable flexibility and commitment.

6.0 Overall conclusions and recommendations

6.1 Conclusions

The role identified for bed-based intermediate care to enable people to leave hospital sooner, return home more safely, and avoid or postpone the need for nursing home placements, is clearly an important one. All the evidence that we reviewed, including what we have been told by patients, relatives, staff and management during our visit, seems to us to provide a clear and coherent picture of a unit at Ronald Gibson House which is making a generally very good job of fulfilling this role in Wandsworth in a positive homely environment within a nursing home. In particular, nursing care and collaborative personalised rehabilitative therapy is provided in a flexible and sensitive manner to mainly older people in need of this "step-down" help, allowing them to return home within a relatively short period after hospitalisation following illness, falls and other injuries. (We saw no evidence of a bed-based "step-up" service working to prevent people in the community from needing to be admitted to an acute hospital setting and we wonder about the relevance of this aspect of the NICE guideline).

We are pleased to report that the balance of the feedback we received from patients and their relatives about the standards of care at RGH was positive although there were a few negative comments and some concerns which deserve to be considered. We mention some suggested areas for possible improvement below.

In particular we must draw attention to the fact that a significant minority of patients whom we spoke to or who left comments in response to their pre-discharge questionnaire over the last 6 months expressed the view that more nursing staff were needed at the IC unit. While we do not feel able to take a definite view on this, it needs to be considered by the service providers (and if necessary the commissioners).

Some of the feedback we received also led us to wonder about the optimum level of rehabilitative therapy, in particular physiotherapy, in bed-based intermediate care. Put simply, the question is whether employing more physiotherapists to carry out a more intensive regime of therapy would allow patients to make speedier progress in recovering mobility, shorten their stay in IC and return home sooner? If so, this would be a better outcome for patients but would the balance of costs be positive or negative? We are not in a position on the basis of our limited visit to RGH to suggest the answers to these questions but we believe that the issue is one that the commissioners and providers could usefully address together.

Nor are we are in a position to comment on the balance of supply and demand for bed-based intermediate care in Wandsworth but in our view there is a clear need for continuing provision of this type at an adequate level for patients who are able to benefit from it.

We may wish to come back to some of these issues after we have made further enquiries including visiting the Inpatient Elderly Rehabilitation Service (Mary Seacole Ward) at Queen Mary's Hospital, Roehampton.

6.2 Recommendations

Staffing and care

In the light of the views of a significant minority of patients and relatives that more nursing staff are needed we suggest that current staff provision should be reviewed.

Staff should be reminded of the need to protect patients' privacy and dignity, especially at busy times such as the early morning.

More attention should be paid to giving medication at appropriate times and, in preparation for discharge, encouraging patients to take their own medication where possible.

Clearer information about the GP's availability and role could be made available to patients.

More care should be given to meeting the needs of patients with special dietary requirements.

Staff should be mindful of patients who are largely confined to their rooms by their physical condition or state of mind. They may be unaware of activities taking place elsewhere in the unit unless specifically informed and may need some active encouragement to come out and participate.

The home should discuss with commissioners the need for a laundry service for patients as an alternative to relying on relatives to provide this. This would ensure all patients could wear their own daytime clothes which we thought contributed positively to their rehabilitation.

We see the absence of any nearby shopping facilities for simple items patients need as a problem. Consideration should be given to how this could be addressed both now and in the future.

Rehabilitation

Since falls appear to be a major cause of admission/readmission to IC, we wonder whether more might be done during a patient's stay to reinforce awareness of the risk of falls and the various interlocking strategies for avoiding them. Greater prominence should be given to the need to identify and implement an appropriate falls prevention strategy for each individual both during their stay and as part of discharge planning.

Although there was clear evidence of collaborative goal-setting, we would like to see goals broken down into their constituent steps, expressed in plain English and for a copy to be given to patients.

Documentation of therapy goal-setting and monitoring should be reviewed and monitored for adherence.

Consideration should be given as to whether the present level of rehabilitative work is optimal or whether increased resources and more intensive therapy might lead to a worthwhile improvement in outcomes.

Information for patients and families

In any redesign of information material for patients and their families, more prominence could usefully be given to providing clear advice on who patients and their carers, friends and families should contact with any queries and concerns.

Discharge

To reduce confusion and anxiety, the unit should identify more clearly when patients enter a "preparation for discharge" stage and, for example, mark this with use of a discharge leaflet for patients and relatives.

26 June 2018

Revised 17 July 2018

Disclaimer

Please note that our findings in this report relate to observations and interviews on particular days. It should not be taken as a representative portrayal of the experiences of all service users and staff associated with the Ronald Gibson House intermediate care facility, over time.